Anthem

Attending Dentist Statement

Check one:

☐ Dentist pre-treatment estimate

☐ Dentist statement of actual services

PATIENT

1. PATIENT NAME (First, Middle, Last)	2. RELATIONSHIP TO SUBSCRIBER	3. SEX	4. PATIENT BIRTHDATE	5. IF FULL TIME STUDENT
	☐ Self ☐ Child ☐ Spouse ☐ Other	☐ M ☐ F	Month / Date / Year	School Name, City

6. SUBSCRIBER NAME AND MAILING ADDRESS	7. SUBSCRIBER IDENTIFICATION NUMBER	8. SUBSCRIBER BIRTHDATE	9. EMPLOYER (Company) NAME AND ADDRESS	10. GROUP NUMBER
ADDRESS CHANGE (Check here) ☐		Month / Day / Year		

11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS?	12-a NAME AND ADDRESS OF CARRIER(S)	12-b GROUP NUMBER(S)	13. NAME AND ADDRESS OF EMPLOYER
Dental ☐ Yes ☐ No Medical ☐ Yes ☐ No			

14-a SUBSCRIBER NAME (if different than patient's)	14-b SUBSCRIBER IDENTIFICATION NUMBER	14-c SUBSCRIBER BIRTHDATE	15. RELATIONSHIP TO PATIENT
		Month / Day / Year	☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER_____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (Patient or parent if minor) Date

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

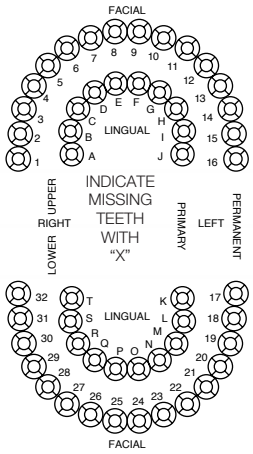
Signed (Insured person) Date

DENTIST

16. DENTIST NAME	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	If yes, enter brief description and dates.
17. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	26. OTHER ACCIDENT?			
CITY, STATE, ZIP	27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(If No, reason for replacement)
18. DENTIST SOC.SEC. OR T.I.N. 19. DENTIST LICENSE NO. 20. DENTIST PHONE NUMBER	28. DATE OR PRIOR PLACEMENT?			

21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT Office / Hosp / ECF / Other	23. RADIOGRAPHS OR MODELS ENCLOSED? NO / YES / HOW MANY?	29. IS TREATMENT FOR ORTHODONTICS?	If services already commenced:	Date appliances placed	Months treatment remaining

Identify missing teeth with "X"



31. Remarks for unusual services

30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc. Line No.	Date Service performed Mo. Day Year	Procedure number	Fee	For Administrative Use Only: DED COPAY	For Administrative Use Only: Benefit Amount
		1.		D			
		2.		D			
		3.		D			
		4.		D			
		5.		D			
		6.		D			
		7.		D			
		8.		D			
		9.		D			
		10.		D			
		11.		D			
		12.		D			
		13.		D			
		14.		D			
		15.		D			
				D			
				D			

I hereby certify that the procedure as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.

Signed (Treating Dentist) Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier pays	
Patient pays	

WHITE/Anthem BCBS – CANARY/Provider

FORM NO. 98668